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9	BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA	
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12	In the Matter of the Accusation Against:	Case No. 2009-33
13	GEORGIA KATHLENE DESCH,	ACCUSATION
14	a.k.a. GEORGIA KATHLENE GIANNOPOULOS, a.k.a. GEORGIA KATHLEEN SILVA 44242 Trubuco Road	ACCUSATION
15	Coarsegold, CA 93614-9058	
16	Registered Nurse License No. 577455	
17	Respondent.	
18		J
19	Complainant alleges:	
20	<u>PARTIES</u>	
21	1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation	
22	solely in her official capacity as the Executive Officer of the Board of Registered Nursing	
23	("Board"), Department of Consumer Affairs.	
24	2. On or about February 21, 2001, the Board issued Registered Nurse License	
25	Number 577455 to Georgia Kathlene Desch, also known as Georgia Kathlene Giannopoulos and	
26	Georgia Kathleen Silva ("Respondent"). Respondent's registered nurse license was in full force	
27	and effect at all times relevant to the charges brought h	erein and will expire on August 31, 2010,
28	unless renewed.	

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in Madera, California (hereinafter "Children's Hospital").

- 8. On November 2, 2002, Respondent was changing the patient controlled analgesia (PCA) bag for Patient A. Respondent asked registered nurse L. Y. to verify the PCA bag change. L. Y. observed that the new bag was already "spiked" (the bag was punctured and the medication tubing was placed into the bag) and that the medication in the bag, morphine sulfate, was not for Patient A (Patient A was being administered Bupivicaine and Fentanyl through his epidural at a rate of 7 cc per hour; the morphine was intended for Patient B). L. Y. pointed out to Respondent that she had placed the wrong epidural bag for Patient A. The morphine bag was removed and wasted as witnessed by L. Y. Respondent documented the wastage of the morphine as occurring on October 31, 2002, on the Controlled Substance Narcotic Record.
- 9. Later that same day, Respondent pulled L. Y. into another patient's room and asked L. Y. not to report Respondent's medication error. Respondent told L. Y. that she would be terminated from her employment if anyone found out about the error.
- 10. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about November 2, 2002, while employed as a registered nurse in the Explorer Unit of Children's Hospital, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as follows:
- a. Respondent reported to work even though her ability to practice nursing safely was impaired due to physical illness.¹
- b. Respondent failed to read the label of the medication (morphine sulfate) she procured from narcotics storage, and failed to check Patient A's arm band and compare it to the label on the syringe before inserting the syringe into the patient's PCA. As a result, Respondent attached a medication to the analgesia pump that was intended for another patient.
- c. Respondent attempted to conceal the medication error, described in subparagraph (b) above, by falsifying the Controlled Substance Narcotic Record (Respondent

^{1.} Respondent provided a declaration under penalty of perjury to an investigator with the Division of Investigation, Department of Consumer Affairs, in which she stated that she was experiencing a health problem on the day of the incident which "distracted her" from her nursing duties.

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1	Taking such other and rather, action as decined necessary and proper.	
2	DATED: 8113108	
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4	RUTH ANN TERRY, M.P.H., R.N. Executive Officer	
5	Board of Registered Nursing Department of Consumer Affairs State of California	
6	State of California	
7	Complainant	
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Taking such other and further action as deemed necessary and proper.